

THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL

January 2015

Volume 10

Issue 1

Inside

- 2 The Pharmacologic and Nonpharmacologic Treatment of Opioid Use Disorder
Rohit Aiyer, M.D.
- 5 A Case of New-Onset Schizophrenia With Gilbert's Syndrome
Cody Armstrong, M.D.
- 7 Pain, Depression, and Delirium: Evaluation of the Complex Consultation-Liaison Patient
Joanna Koutros, M.D.
- 9 Revisiting the Guidelines for Violence Risk Assessment of Patients in the Psychiatric Emergency or Inpatient Setting
Swapnil Rath, M.D.
- 11 Toward Forging a National Policy for Police Mental Health Training
Rehan Puri, M.D., M.P.H.
- 12 Marijuana and Madness, 2nd Edition
Review by Tony Pham, B.A.
- 15 Residents' Resources

In This Issue



This month's issue of the *Residents' Journal* focuses on a variety of topics. Rohit Aiyer, M.D., examines the pharmacologic and nonpharmacologic treatment of opioid use disorder and provides discussion of diagnostic criteria, withdrawal symptoms and monitoring, relapse prevention, and overdose. In a case report, Cody Armstrong, M.D., explores the link between schizophrenia with Gilbert's syndrome in a patient with changing bilirubin levels. In another case report, Joanna Koutros, M.D., emphasizes the effect of depression on a patient's somatic complaints and the importance of recognizing symptom clusters. Swapnil Rath, M.D., outlines and explains the guidelines for violence risk assessment in the psychiatric emergency or inpatient setting. Rehan Puri, M.D., M.P.H., comments on a national policy for police mental health training. Lastly, Tony Pham, B.A., reviews the second edition of *Marijuana and Madness*.



NEW INDICATION Schizoaffective Disorder as:

- Monotherapy
- Adjunct to mood stabilizers or antidepressants

[LEARN MORE](#)

Prescribing Information

INVEGA® SUSTENNA® is indicated for:

- Schizoaffective disorder as monotherapy and as an adjunct to mood stabilizers or antidepressants.

IMPORTANT SAFETY INFORMATION FOR

© Janssen Pharmaceuticals, Inc. 2014 021072-140908

Editor-in-Chief
Misty Richards, M.D., M.S.

Senior Deputy Editor
Rajiv Radhakrishnan, M.B.B.S., M.D.

Deputy Editor
Tobias Wasser, M.D.

Associate Editors
Ijeoma Chukwu, M.D., M.P.H.
Kathleen Mary Patchan, M.D.

Media Editor
Holly S. Peek, M.D., M.P.H.

Staff Editor
Angela Moore

Editors Emeriti
Sarah B. Johnson, M.D.
Molly McVoy, M.D.
Joseph M. Cerimele, M.D.
Sarah M. Fayad, M.D.
Monifa Seawell, M.D.
Arshya Vahabzadeh, M.D.

The Pharmacologic and Nonpharmacologic Treatment of Opioid Use Disorder

Rohit Aiyer, M.D.

Opioid prescription analgesics are responsible for more deaths than the combined number of deaths from both suicide and motor vehicle accidents (1). In addition, opioid use disorder has a serious economic impact in the United States, with total costs of prescription opioid abuse estimated at \$55.7 billion in 2007. Workplace costs accounted for \$25.6 billion (46%), health care costs accounted for \$25.0 billion (45%), and criminal justice costs accounted for \$5.1 billion (9%) (2). Opioid use disorder is an epidemic issue in the United States that needs to be addressed and taken very seriously by American health care providers, particularly psychiatrists.

Opioid Use Disorder Diagnostic Criteria

In DSM-IV, there were two separate diagnoses: substance abuse and substance dependence. In DSM-5, the abuse and dependence criteria have been combined into one disorder, and the diagnosis has been renamed “substance use disorder.” DSM-5 states that a patient is considered to have an opioid use disorder if he or she has a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by two of 11 criteria, which are clustered into the following four groups: impaired control, social impairment, risky use, and pharmacologic dependence (3).

Opioid Withdrawal

Symptoms and Monitoring

Opioid withdrawal can be monitored using scales such as the Clinical Opiate Withdrawal Scale. The withdrawal syndrome usually includes symptoms and signs of CNS hyperactivity, such as lacrimation, agitation, nausea, rhinorrhea, increased respiration rate, insomnia, and stomach cramps (4).

Treatment

Methadone is a synthetic, long-acting opioid with pharmacologic actions similar to morphine (see Table 1). It is primarily a full-receptor agonist and simulates the action of endogenous opioids and affects the release of the neurotransmitters glutamate, norepinephrine, dopamine, acetylcholine, and serotonin. Methadone also competitively inhibits *N*-methyl-D-aspartate (4). According to World Health Organization (WHO) guidelines, for patients using street opioids, such as heroin, methadone doses of 20 mg/day will typically be adequate to relieve withdrawal symptoms and retain patients in treatment. When it is established that the initial dose is well tolerated, the methadone dose should be gradually increased until the patient is comfortable and not using heroin or other illicit opioids (5). Buprenorphine, a partial mu-agonist and antagonist at the kappa opioid receptor, has been shown to be effective and safe as a treatment for withdrawal symptoms (see Table 1). Buprenorphine combined with naloxone is the variation preferred for withdrawal therapy in opioid use disorder patients (6). Detoxification can also be accomplished by symptomatic treatment of opioid withdrawal using medications such as clonidine (for autonomic hyperactivity), nonsteroidal anti-inflammatory drugs (for malaise and myalgias), antidiarrheals and antispasmodics (for diarrhea and abdominal cramps), and ondansetron (for nausea) (7).

Maintenance Treatment of Opioid Use Disorder

For methadone maintenance treatment, WHO guidelines state that doses in the range of 60 mg–109 mg are the most effective (5). There are many proposed ratios to convert dosages from morphine to methadone, ranging from 4:1 to 40:1 (oral morphine:oral methadone). The rate of increase should be individu-

ally assessed and should not be >10 mg every few days (8). The literature shows that there are several methods to calculate and convert, and Weschules and Bain (9) reviewed several of these methods and concluded that there is no superiority in any one conversion protocol.

Buprenorphine maintenance treatment doses studied for opioid addiction treatment have ranged from 1 mg–2 mg to 16 mg–32 mg, depending upon the formulation (solution versus tablet), with the duration of treatment lasting from a few weeks to years. There are three phases in buprenorphine maintenance treatment that should be addressed. The first is the induction phase, which involves helping the patient to initiate the process. The second phase is the stabilization phase, which lasts 1–2 months and is started when the patient is not experiencing withdrawal symptoms. The third phase is maintenance, which can last for an indefinite period and focuses on prevention of relapse (10).

Buprenorphine/naloxone comprises the partial mu-opioid receptor agonist buprenorphine in combination with the opioid antagonist naloxone in a 4:1 ratio, respectively. When buprenorphine/naloxone is taken sublingually as prescribed, the naloxone exerts no clinically significant effect, leaving the opioid agonist effects of buprenorphine to predominate. Less frequent dispensing of buprenorphine/naloxone (e.g., three times per week) is a major advantage of this intervention and therefore can improve patient satisfaction (11).

Pharmacologic Treatment of Opioid Use Disorder

Relapse Prevention

Relapse involves use of a substance, such as heroin, following a week or more of abstinence, or one day of heavy use during a time when the patient has been drug-free

TABLE 1. Pharmacologic Treatments for Opioid Use Disorder^a

Drug	Dosage	Pharmacokinetics	Pharmacodynamics	Side Effects	Drug-Drug Interactions
Methadone	60 mg–110 mg	Rapidly absorbed from the gastrointestinal tract and can be detected in the blood within 30 minutes.	Mu-agonist and N-methyl-D-aspartate antagonist.	Dizziness, drowsiness, nausea, vomiting, and sweating.	There are additive CNS depressive effects. Can potentiate the deleterious effects of alcohol. There is also strong evidence for QTc prolongation.
Buprenorphine	8 mg–32 mg	Broken down into norbuprenorphine and glucuronidation.	A partial agonist at the mu-opioid receptor and an antagonist at the kappa-opioid receptor.	Headache, nausea, insomnia, abdominal pain, and sweating.	CYP3A4 Inhibitors and inducers.
Buprenorphine plus naloxone	8 mg plus 2 mg–16 mg plus 4 mg	Broken down into norbuprenorphine and glucuronidation.	Buprenorphine is a partial agonist at the mu-opioid receptor and an antagonist at the kappa-opioid receptor. Naloxone is a potent antagonist at mu-opioid receptors.	Headache, pain, insomnia, constipation, sweating, and nausea.	Benzodiazepine, erythromycin, itraconazole, an HIV protease inhibitor, rifampin, phenytoin, carbamazepine, and a barbiturate such as phenobarbital.
Naltrexone	50 mg	Subject to significant first-pass metabolism.	Pure opioid antagonist (mu receptor).	Blurred vision, tachycardia, hallucinations, nausea, stomach pain, and lower fever.	Safety is unknown, and the concomitant use of two are potentially hepatotoxic medications.
Naloxone	0.02 mg, 0.4 mg, and 1.0 mg per mL	Rapidly distributed in the body.	Pure opioid antagonist (mu receptor).	Chest pain, tachycardia, dry cough, sweating, nausea, headache, and seizures.	Large dosages are required to antagonize buprenorphine.

^a Data were obtained from the RxList (<http://www.rxlist.com>).

and is attempting to maintain abstinence. To counter relapse and prevent future episodes, Marlatt and Donovan (12) suggested six strategies to help clinicians: remain nonjudgmental with clients; encourage patients to return to treatment quickly after relapse; limit the harm associated with relapse episodes; educate clients on prevention and management of overdose; discuss less harmful ways to use drugs; and examine use of drugs other than opioids.

Naltrexone is an opioid antagonist that competitively blocks opioid receptors (see Table 1). The blockade depends on the concentration of agonists to antagonists and their affinity for opioid receptors. Pharmacologically, naltrexone is an effective treatment for heroin relapse prevention (6). Naltrexone is also available in an extended sustainable release form. However, psychiatrists should be aware of the liver dysfunction it can cause (13).

Overdose

Naloxone is a nonselective short-acting opioid receptor antagonist and is presently considered a safe drug for the treatment of acute intoxication (see Table 1). Naloxone is typically administered intravenously at a dosage of 0.4 mg (alternative routes include intramuscular and subcutaneous injections) to rapidly reverse unconsciousness and apnea. Patients treated for opioid acute intoxication should be hospitalized and observed for at least 24 hours (14).

Nonpharmacologic Treatment of Opioid Use Disorder

Cognitive-Behavioral Therapy (CBT)

CBT primarily aims to change addictive behavior through changes in faulty thoughts and cognitions that serve to maintain the behavior or through positive cognitions or motivation to promote

change in behavior (15). CBT intervention has been proposed by researchers to have great potential, particularly in prison settings where CBT programs are less costly to implement, because it requires fewer demands and less space to conduct compared with other therapeutic interventions, such as a therapeutic community approach. A meta-analysis of 69 studies examining the effectiveness of CBT, conducted by Pearson et al. (16), found that such treatment was generally superior to standard correctional programming in reducing recidivism; however, this meta-analysis was limited with regard to the quality of the studies included (17).

Contingency Management

Contingency management treatments involve three basic principles: 1) frequently monitoring for change in the behavior desired, 2) reinforce the desired behavior each time it occurs, and 3) withhold

positive reinforcers when the desired behavior does not occur (18). Petry and Carroll (19) examined the addition of contingency management as an adjunct to standard community-based treatment (methadone maintenance and monthly individual counseling) for opioid-dependent patients. Patients in the contingency management intervention achieved longer durations of abstinence throughout a 6-month follow-up period compared with those who did not receive contingency management.

Conclusions

A variety of treatment options for opioid use disorder are available, and it is essential for physicians in this field to know how to optimize the treatment of opioid use disorder for patient care. There is a growing burden of opioid use disorder, and these interventions will continue to make significant impact in psychiatry private practices with regard to patient care. While general psychiatrists can utilize a variety of treatments, they should also be comfortable in referring to addiction psychiatrists when it is clinically warranted for the patient.

Dr. Aiyer is a first-year resident in the Department of Psychiatry, North Shore-LIJ Health System–Staten Island University Hospital, Staten Island, N.Y.

The author thanks Harshal Kirane, M.D., Director of Addiction Services at North Shore-LIJ Health System–Staten Island University Hospital.

References

1. Manchikanti, Helm S, Fellows B, et al: Opioid epidemic in the United States. *Pain Physician* 2012; 15:ES9–ES38
2. Birnbaum HG, White AG, Schiller M, et al: Societal costs of prescription opioid abuse, dependence and misuse in the United States. *Pain Med* 2011; 12:657–667
3. Hilaire ML, Woods TM: Opioid abuse and dependence: treatment review and future options. *Formulary* 2010; 45:284–291
4. Merck: Opioids: The Merck Manual Professional Edition. Whitehouse Station, NJ, Merck Sharp and Dohme Corp, 2013
5. World Health Organization: Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva, World Health Organization, 2009
6. American Society for Addiction Medicine: Public Policy Statement on Buprenorphine for Opioid Dependence and Withdrawal. Chevy Chase, Md, American Society of Addiction Medicine, 2006
7. Smithedajkul PY, Cullen MW: Managing acute opiate withdrawal in hospitalized patients. *ACP Hospitalist*, Oct 2009
8. Volkow N: America's addiction to opioids: heroin and prescription drug abuse. Bethesda, Md, National Institute on Drug Abuse, 2014
9. Weschules DJ, Bain KT: A systematic review of opioid conversion ratios used with methadone for the treatment of pain. *Pain Med* 2008; 5:595–612
10. Center for Substance Abuse Treatment: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction–Treatment Improvement Protocol (TIP) Series, No 40. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2005
11. Toombs J, Kral L: Methadone treatment for pain states. *Am Fam Physician* 2005; 71:1353–1358
12. Marlatt A, Donovan D: Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. New York, Guilford Press, 2005, pp 151–153
13. Taylor R Jr, Raffa RB, Pergolizzi JV: Naltrexone extended-release injection: an option for the management of opioid abuse. *Subst Abuse Rehabil* 2011; 2:219–226
14. Krupitsky E, Zvartau E, Woody G: Use of naltrexone to treat opioid addiction in a country in which methadone and buprenorphine are not available. *Curr Psychiatry Rep* 2010; 12:448–453
15. Ebrahimi S, Ghasemian D, Khosravi M: Effects of a period CBT on mental health of homeless women in recovery phase of narcotics addict. *J Nov Appl Sci* 2014; 3:362–366
16. Pearson FS, Lipton DS, Cleland CM, et al: The effects of behavioral/cognitive-behavioral programs on recidivism. *Crime Delinquen* 2002; 48:476–496
17. Bennett L: New Topics in Substance Abuse Treatment. Halifax, Nova Scotia, Canada, Nova Science Publishers, 2006, p 85
18. McHugh K, Hearon BA, Otto MW: Cognitive-behavioral therapy for substance use disorders. *Psychiatr Clin North Am* 2010; 33:511–525
19. Petry NM, Carroll KM: Contingency management is efficacious in opioid-dependent outpatients not maintained on agonist pharmacotherapy. *Psychol Addict Behav* 2013; 27:1036–1043

THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL

Let us Know Your Thoughts

Please complete our survey at
<https://www.surveymonkey.com/s/ZRNGTJH>



A Case of New-Onset Schizophrenia With Gilbert's Syndrome

Cody Armstrong, M.D.

There have been few studies showing an association between schizophrenia and Gilbert's syndrome, with existing studies reporting a 20% prevalence of Gilbert's syndrome in persons with schizophrenia, compared with 3%–7% in the adult population (1). Most of the research around this phenomenon has dealt with theories related to hyperbilirubinemia as a causal factor, differences in severity of symptoms between individuals with and without hyperbilirubinemia, and changes on brain imaging, with most subjects having established schizophrenia (2–4). The present case is of a young man with changes in bilirubin observed in four hospitalizations.

Case

“Mr. T” is a 25-year-old single, active-duty service member in the U.S. Navy, with 4 years of continuous service. On his first admission to the hospital, he was medically evacuated from Italy due to disorganized behavior and thought processes after presenting to the emergency department with stomach pains in the context of a restricted 500 kcal diet for several weeks. By the time he had arrived back in the United States to see a psychiatrist, mental status examination revealed mild concreteness of thought. The patient's laboratory work-up, which included complete blood count, chemistry panels, liver function tests, rapid plasma reagin test, thyroid-stimulating hormone measurement, urinalysis, and urine drug screen for “spice” and “bath salts,” was unremarkable. At that time, he was returned to Italy, with the thought that his presentation could have been delirium that had cleared. After 1 week back in Italy, he presented in the same way to the emergency department, with disorganized behavior and thought processes, as well as gastrointestinal complaints. Once again, by the time he was evacuated and sent back to

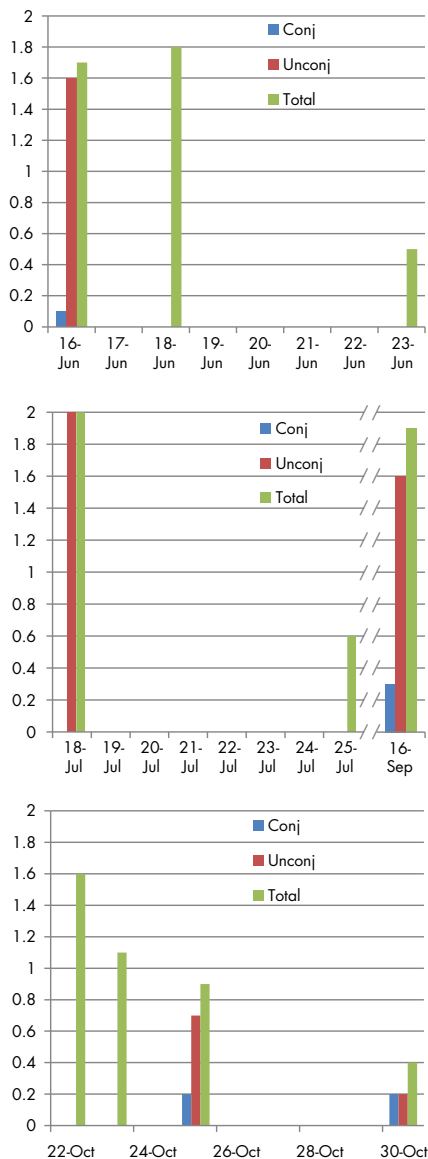
the United States, his examination only revealed mild concreteness. He underwent psychological testing, including the Millon Clinical Multiaxial Inventory, the Personality Assessment Inventory, and the Structured Inventory of Malingered Symptomatology, none of which revealed any abnormalities. At this point, it was decided that the patient should remain in the local area in a limited duty status so that he could be observed if another episode occurred. About 1 month later, he was once again seen in the emergency department with stomach pain and disorganized thoughts and behaviors and was admitted. This was the first time that he saw a psychiatrist while he was experiencing symptoms, and he was observed to be concrete but to have difficulty with memory. He was evaluated for acute intermittent porphyria, with negative results, and he was discharged on aripiprazole 5 mg daily. One month later, he returned for his fourth admission, brought in by police from the airport because he attempted to board a plane without a ticket and used his tattoos with his name on them as identification. He did not have any official identification, and his supervisor had not approved vacation leave. On this admission, he appeared more disorganized than he did previously. While on the ward, he punched out the glass inside the exit door in an attempt to escape. He had not shown any aggressive or agitated behavior while in the United States in the psychiatric unit prior to this admission, although there were reports of some mild agitation while he was in Italy. On this admission, he received an MRI scan, which did not show any pathology. He also underwent a Rorschach test after his psychosis had cleared, but the test did not indicate any evidence of an overtly psychotic thought process. On this admission, his presentation was much more convincing for psychosis, and his daily

dose of aripiprazole was increased to 15 mg, and a diagnosis of schizophreniform disorder was given at discharge. Also on this admission, it was noticed that his bilirubin level was elevated slightly, to 1.6 mg/dL. Upon record review, it was discovered that his bilirubin level had been mildly elevated at each of his four presentations, mainly consisting of unconjugated bilirubin, with resolution by the time of discharge (see Figure 1). The elevation in unconjugated bilirubin was consistent with a diagnosis of Gilbert's syndrome, a typically benign syndrome.

Discussion

There are few studies of the connection between schizophrenia and hyperbilirubinemia (1, 5). These studies mainly show an increased prevalence of unconjugated hyperbilirubinemia among persons with schizophrenia and suggest a connection with chronic hyperbilirubinemia and neuronal damage as one possible etiology for schizophrenia (4). Most of these studies have been performed with patients presenting much later in the clinical course. In the above case, the patient appeared without detectable psychotic processes in-between events and was able to function at a high level. His supervisor noted good performance at work, with minimal supervision (e.g., showing up on time, always getting the job done), and he was able to obtain an apartment and a car without assistance. Additionally, it is interesting that for almost 2 months during this period, the patient was not taking any medication, and for the remainder of the time, he was only receiving aripiprazole 5 mg/day, discontinuing treatment 1 week prior to his fourth admission. Also intriguing is that psychological testing done in-between episodes did not indicate any pathology, and the patient's acute symptoms coincided perfectly with elevated unconjugated bilirubin and reso-

FIGURE 1. Levels of Conjugated and Unconjugated Bilirubin in a Patient Presenting With Disorganized Thoughts and Gastrointestinal Complaints^a



^a Conj=conjugated; Unconj=unconjugated.

lution coincided perfectly with a return to normal values.

This raises the question as to which comes first. Are the psychotic symptoms somehow brought on by the increase in unconjugated bilirubin, or is the elevated bilirubin level a response to psychotic symptoms? One method that could be used to determine this would be to induce hyperbilirubinemia in patients with

known Gilbert's syndrome and a history of psychosis by restricting calories when they are not experiencing psychosis to see whether they then became psychotic. Another method would be to perform serial liver function tests in these patients to see how fluctuations in unconjugated bilirubin match up with psychotic symptoms.

One study found that elevations in unconjugated bilirubin levels were only seen in patients with acute and transient psychotic disorder, based on ICD-10 criteria, which is partially equivalent to brief psychotic disorder, and not schizophrenia, in DSM-5 (6). This study also suggested that the increase in unconjugated bilirubin may not be due to Gilbert's syndrome because some of the participants with unconjugated hyperbilirubinemia associated with psychosis lacked the *UGT* gene mutation of Gilbert's syndrome. Additionally, it would be interesting to see whether levels of bilirubin differed in patients with acute and transient psychotic disorder that occurred once compared with several times as in our patient.

Another element to test would be to determine whether preventing the rises in bilirubin could alter the course of the disease. Several suggestions for controlling bilirubin have come from research on the treatment of Crigler-Najjar syndrome. Suggested treatments for control of unconjugated bilirubin include calcium phosphate, orlistat, corticosteroids, avoiding low-calorie diets, and avoiding stress (7–10).

Conclusions

There is a well-documented but not so well understood connection between schizophrenia and Gilbert's syndrome. Although as many as 20% of persons with schizophrenia have Gilbert's syndrome, there is not much research on this connection. More studies on this topic should be conducted, since this could be an endophenotype of schizophrenia.

Dr. Armstrong is a third-year resident in the Department of Mental Health, Naval Medical Center, San Diego.

The author thanks his mentor, Dr. Ashbrook, Division Officer for Inpatient Mental

Health of the Department of Mental Health, Naval Medical Center, for guidance in the formulation of this article.

References

1. Miyaoka T, Seno H, Itoga M, et al: Schizophrenia-associated idiopathic unconjugated hyperbilirubinemia (Gilbert's syndrome). *J Clin Psychiatry* 2000; 61:868–871
2. Wake R, Miyaoka T, Tsuchie K, et al: Abnormalities in MRI signal intensity in schizophrenia associated with idiopathic unconjugated hyperbilirubinemia. *Aust N Z J Psychiatry* 2009; 43:1057–1069
3. Yasukawa R, Miyaoka T, Mizuno S, et al: Proton magnetic resonance spectroscopy of the anterior cingulate gyrus, insular cortex and thalamus in schizophrenia associated with idiopathic unconjugated hyperbilirubinemia (Gilbert's syndrome). *J Psychiatry Neurosci* 2005; 30:416–422
4. Brites D, Fernandes A, Falcao AS, et al: Biological risks for neurological abnormalities associated with hyperbilirubinemia. *J Perinatology* 2009; 29(suppl):S8–S13
5. Radhakrishnan R, Kanigere M, Menon J, et al: Association between unconjugated bilirubin and schizophrenia. *Psychiatry Res* 2011; 189:480–482
6. Bach DR, Kindler J, Strik WK: Elevated bilirubin in acute and transient psychotic disorder. *Pharmacopsychiatry* 2010; 43:12–16
7. Van Der Veere CN, Schoemaker B, Bakker C, et al: Influence of dietary calcium phosphate on the disposition of bilirubin in rats with unconjugated hyperbilirubinemia. *Hepatology* 1996; 24:620
8. Ohkubo H, Okuda K, Iida S: Effects of corticosteroids on bilirubin metabolism in patients with Gilbert's syndrome. *Hepatology* 1981; 1:168
9. Hafkamp AM, Nelisse-Haak R, Sinaasappel M, et al: Orlistat treatment of unconjugated hyperbilirubinemia in Crigler-Najjar disease: a randomized controlled trial. *Pediatr Res* 2007; 62:725
10. Hafkamp AM, Havinga R, Sinaasappel M, et al: Effective oral treatment of unconjugated hyperbilirubinemia in Gunn rats. *Hepatology* 2005; 41:526

Pain, Depression, and Delirium: Evaluation of the Complex Consultation-Liaison Patient

Joanna Koutros, M.D.

Somatic pain has been shown to negatively affect the recognition of depression, as well as treatment (1). The present case is of a middle-aged woman who experienced abdominal pain likely affected by her history of major depressive disorder.

Case

“Ms. M” is a 59-year-old divorced African American woman with a history of major depressive disorder and multiple medical comorbidities. She was admitted to the inpatient medicine service with abdominal pain consistent with prior episodes of pancreatitis. However, laboratory testing and diagnostic imaging did not support a diagnosis of acute pancreatitis. The psychiatry consultation liaison team was consulted for a psychosomatic evaluation of the patient because the primary team felt that her complaints of pain were out of proportion with her physical examination. Upon interview, she discussed various psychosocial stressors, including her daughter who had been admitted to the intensive care unit and the upcoming 1-year anniversary of her son’s death. It became clear that she was suffering from a recurrent moderate major depressive episode, without suicidal ideation or psychosis. She felt that citalopram, which she had been taking for the last 15 years, was no longer working. Consequently, the psychiatry consultation liaison team recommended switching to duloxetine for the dual purpose of treating her depression and pain. She was also advised to follow up at her previously scheduled outpatient appointment in 2–3 weeks.

Two weeks later, the consultation liaison team was consulted again regarding the patient, who was readmitted into the intensive care unit following a suicide attempt by overdose. The consultation liaison team was initially concerned that she would be unable to tolerate evaluation due to her medical complications;

however, the primary team was adamant that she was alert, oriented, cooperative, and capable of being interviewed. It was discovered that in the time since the initial consult, her ill daughter had passed away—on the same day as the 1-year anniversary of her son’s death. Furthermore, she had stopped taking her antidepressants after the most recent hospital discharge because her insurance would not cover the prescription for duloxetine. Evaluation of the patient’s mental status in the intensive care unit revealed disorientation, inability to process and register questions, decreased production of speech with frequent staring, inattention, and memory impairment. She did not exhibit any hallucinations, delusions, or agitation, making her symptoms consistent with hypoactive delirium.

Discussion

This case illustrates several missed opportunities on the part of the treating physicians that could have resulted in better patient care. First, at the time of the patient’s initial presentation, the primary team did not recognize the significance and impact of depression on her subjective experience of abdominal pain. Second, while the psychiatry consultation liaison team chose a reasonable agent, they did not ensure insurance coverage of her new prescription or closer outpatient follow-up. Lastly, upon her readmission, the intensive care unit team did not identify her cluster of symptoms as delirium because she lacked more of the striking features of hyperactive delirium.

The literature shows that there is a clear link between pain and depression. One study showed that 75%–80% of patients fulfilling the criteria for depression reported painful somatic symptoms, such as headache, abdominal pain, neck and back pain, and nonspecific generalized pain (1). Conversely, patients with somatic pain

are four times more likely to develop anxiety or depressive disorders than patients who are pain-free (2). In addition, somatic pain has been shown to negatively affect the recognition and treatment of depression (1). The above case is a prime example of this effect. The primary team was so focused on the patient’s frequent complaints of pain and requests for pain medication that they were unable to recognize its connection to her underlying depression. Furthermore, there is a strong correlation between pain and suicide (2). One particular study demonstrated that the prevalence of suicidality (passive and active ideation, as well as attempts) was two to three times greater in subjects with chronic abdominal pain compared with those without pain (3).

Although it is impossible to specify why this patient attempted suicide, the discontinuation of her antidepressant treatment during an already difficult and stressful time was a likely contributor. There have been many epidemiological studies worldwide that have shown a reduction in suicide rates in regions with increased antidepressant prescription (4–6). Moreover, autopsy studies have shown that only 8%–20% of patients diagnosed with depression who completed suicide were found to be positive for antidepressants on postmortem toxicology testing (7, 8). These findings suggest that antidepressants have a protective effect on suicidality, and lack of antidepressant treatment has a negative effect. Another study demonstrated that antidepressant initiation, dose changes, and discontinuation all specifically increased risk for suicide attempt (9). This is of particular relevance to the case presented above in which the patient attempted suicide shortly after initiation and discontinuation of a new antidepressant.

As a consequence of this patient’s suicide attempt, she suffered several medical

complications, including hypoxia, metabolic derangements, and aspiration pneumonia, which all likely contributed to her delirium. Phenomenological studies have classified delirium, based on symptoms, into three motoric subtypes: hyperactive, hypoactive, and mixed (10). Hyperactive delirium classically manifests as restlessness, agitation, and hyperalertness, and patients frequently display hallucinations and delusions. On the other hand, hypoactive delirium manifests with lethargy, drowsiness, and sedation. Patients typically respond slowly to questions and have a paucity of spontaneous movements. Patients with mixed delirium display symptoms of both hyperactive and hypoactive subtypes (11). The diagnosis of delirium is very common in the intensive care unit, with a prevalence rate over 70% in patients older than 65 years old and greater than 55% in patients younger than 65 years old (12, 13). One study found that in the intensive care unit setting, mixed delirium had the highest prevalence (54.9%), followed by hypoactive delirium (43.5%), and hyperactive delirium (1.6%) (12). Furthermore, geriatric patients in the intensive care unit experienced a higher rate of hypoactive delirium compared with younger patients (41.0% versus 21.6%) and were never diagnosed with hyperactive delirium (12). The diagnosis of delirium can be missed for various reasons. One study demonstrated that hypoactive delirium was one of four independent risk factors for the under-recognition of delirium by clinicians (14). As explained in the article, “Nurses tended to use patient behavior as an indication of cognitive function, and they mistook compliance as an indication of intact cognition. Thus, cooperative patients with hypoactive delirium were consistently not identified” (14). This line

of reasoning may account for why the symptoms of the patient in the above case were not identified as delirium initially.

Conclusions

It is important to learn from the missed opportunities of this case. Underestimating the impact of depression on various somatic complaints may lead to the undertreatment of depression in some patients. When considering treatment options, psychiatrists should consider nonclinical factors, such as the affordability and accessibility of medications, in order to increase the likelihood of compliance, thereby decreasing the likelihood of the possibly lethal consequences of discontinuation. Finally, clinicians need to be vigilant for hypoactive signs of delirium in order to ensure that patients are accurately diagnosed and underlying medical causes are appropriately treated.

At the time this article was accepted for publication, Dr. Koutros was a fourth-year resident in the Department of Psychiatry, University Hospitals of Cleveland.

The author thanks Jeanne Lackamp, M.D., for her guidance in preparation of this article.

References

1. Kirmayer LJ, Robbins JM, Dworkind M, et al: Somatization and the recognition of depression and anxiety in primary care. *Am J Psychiatry* 1993; 150:734–741
2. Lépine JP, Briley M: The epidemiology of pain in depression. *Hum Psychopharmacol Clin Exp* 2004; 19:S3–S7
3. Magni G, Rigatti-Luchini S, Fracca F, et al: Suicidality in chronic abdominal pain: an analysis of the Hispanic Health and Nutrition Examination Survey (HHANES). *Pain* 1998; 76:137–144
4. Grunebaum MF, Ellis SP, Li S, et al: Antidepressants and suicide risk in the

United States, 1985–1999. *J Clin Psychiatry* 2004; 65:1456–1162

5. Carlsten A, Waern M, Ekedahl A, et al: Antidepressant medication and suicide in Sweden. *Pharmacoevidemiol Drug Saf* 2001; 10:525–530
6. Barbui C, Campomori A, D’Avanzo B, et al: Antidepressant drug use in Italy since the introduction of SSRIs: national trends, regional differences and impact on suicide rates. *Soc Psychiatry Psychiatr Epidemiol* 1999; 34:152–156
7. Yerevanian BI, Koek RJ, Feusner JD, et al: Antidepressants and suicidal behaviour in unipolar depression. *Psychiatr Scand* 2004; 110:452–458
8. Isacson G, Bergman U, Rich CL: Antidepressants, depression and suicide: an analysis of the San Diego Study. *J Affect Disord* 1994; 32:277–286
9. Valuck RJ, Orton HD, Libby AM: Antidepressant discontinuation and risk of suicide attempt: a retrospective, nested case-control study. *J Clin Psychiatry* 2009; 70:1069–1077
10. Meagher DJ, O’Hanlon D, O’Mahony E, et al: Relationship between symptoms and motoric subtype of delirium. *J Neuropsychiatry Clin Neurosci* 2000; 12:51–56
11. Liptzin B, Levkoff SE: An empirical study of delirium subtypes. *Br J Psychiatry* 1992; 161:843–845
12. Peterson JF, Pun BT, Dittus RS, et al: Delirium and its motoric subtypes: a study of 614 critically ill patients. *J Am Geriatr Soc* 2006; 54:479–484
13. McNicoll L, Pisani MA, Zhang Y, et al: Delirium in the intensive care unit: occurrence and clinical course in older patients. *J Am Geriatr Soc* 2003; 51:591–598
14. Inouye SK, Foreman MD, Mion LC, et al: Nurses’ recognition of delirium and its symptoms: comparison of nurse and researcher ratings. *Arch Intern Med* 2001; 161:2467–2473

Revisiting the Guidelines for Violence Risk Assessment of Patients in the Psychiatric Emergency or Inpatient Setting

Swapnil Rath, M.D.

On July 24, 2014, Richard Plotts shot and killed his case worker at Mercy Fitzgerald Hospital in Yeadon, Pa. After the crime, it was reported that Mr. Plotts had received psychiatric care, which renewed the debate in local newspapers about the association between violence and mental illness. This debate contributes to negative public attitudes toward persons with serious mental illnesses (1). Although severe mental illness does not independently predict future violent behavior, there are other factors that, if present in a psychiatric patient, can increase the risk for violence (2). These risk factors include certain demographic characteristics such as younger age, male sex, lower educational level, financial hardship, unemployment, and homelessness (3). Hence, there is need to conduct a violence risk assessment in this population, which can be performed using actuarial methods, clinical methods, or structured clinical judgment (4). Actuarial methods use structured instruments to predict the risk of violence in the long-term. Clinical methods help to evaluate the risk of violence in the short-term, which is useful to clinicians in evaluating patients in the psychiatric emergency or inpatient setting. Structured clinical judgment is a third approach, which is a synthesis of the first two approaches and utilizes violence risk assessment tools, such as the Historical Clinical Risk Management-20, to help inform and guide clinical decision making.

Below is a compilation of guidelines and principles to inform mental health clinicians in performing violence risk assessments (based on a review of the literature [4, 5])

Guidelines to Perform a Violence Risk Assessment

1. It would be preferable for patients to be searched and disarmed if they are carrying weapons on arrival to psychiatric facilities (5).
2. When interviewing a patient in a closed room, clinicians should be closer to the door in case an emergency arises. On the other hand, some patients may feel “trapped” in a room, resulting in worsening paranoia and aggression. Hence, ideally, the clinician and patient should be equidistant from the door, without either acting as a barrier to the other person’s egress (6). The presence of a panic button or switch in rooms where patient encounters occur would also be helpful in crisis situations (5).
3. There are rating scales, such as the Overt Aggression Scale (which measures aggressive behaviors in adults and children) (7) and the Violence and Suicide Assessment Scale (which covers 10 areas related to suicide and violence for use in the emergency department) (8).
4. Assess for risk factors that increase risk for violence, including younger age, male sex, lower educational level, financial hardship, unemployment, and homelessness (4).
5. Try to understand if there are any stressors behind a patient’s violent intentions. Patients who are concerned about their own safety may lash out as a form of self-defense (5).
6. Obtain a detailed history of any past acts of violence through medical records, police records, family reports, and information from any intended victim(s), which can serve as a predictor of future violence (4, 5).
7. Identify where the patient is on the continuum of violence. What is labeled “homicidal” on an intake sheet may range from globally aggressive thoughts to a specific lethal plan with means to carry out the plan. Using a good clinical interview, assess for the presence of violent ideation, degree of planning, intent, and available means (4, 5).
8. Assess for the presence of psychopathology. Loss of reality is a risk factor, as are paranoid delusions and command hallucinations. Poor impulse control in disorders such as mania, delirium, intoxication, and certain personality disorders are additional risk factors (4, 5).
9. Alcohol or illicit drug use can increase risk of violence through intoxication, withdrawal, or cognitive deficits related to chronic use (4, 5). Substance misuse has been consistently shown to be a significant risk factor for violence (9).
10. Look for factors reducing the likelihood for homicidal behavior. Religious beliefs, fear of legal consequences, or a capacity for empathy can be protective factors (5).
11. Avoid “no-homicide contracts” on discharge. They fail to meet defined standards of legal contracts and falsely reassure the clinician that a risk has disappeared (5).
12. Do not hesitate to ask for a second opinion. This may have multiple benefits, such as reducing the risk of litigation, increasing or decreasing concern about disposition, and helping the clinician to gain perspective

- on his or her own countertransference (5).
13. Document the dispositional decision and its rationale. This will help the receiving clinician assess the patient's continuing homicidal risk. The disposition should include what to do if the patient experiences homicidal thoughts again (4, 5).
 14. Remember legal duties: the duty to protect a patient's intended victim(s), which may include notifying the police and/or hospitalizing the patient. Most cases of violence toward others would include legal or criminal penalties (4, 5). Legal duties vary by each state, and thus clinicians should consult their individual state statutes to guide decision making (5).
 15. Do not forget to perform a suicide risk assessment. Patients presenting with homicidal ideations are at greater risk of hurting themselves (5).

Conclusions

As residents, we are on the "frontline" when assessing patients for their risk of

violence. The above guidelines may help to guide mental health clinicians in determining those patients with the greatest propensity for violence. These guidelines are by no means exhaustive or all-inclusive, and further research is needed in this area.

Dr. Rath is a fourth-year resident in the Department of Psychiatry, St. Mary Mercy Hospital, Livonia, Mich.

The author thanks William Cardasis, M.D., for his comments during the preparation of this article. The author also thanks Tobias Wasser, M.D., for editorial advice.

References

1. McGinty EE, Webster DW, Jarlenski M, et al: News media framing of serious mental illness and gun violence in the United States, 1997–2012. *Am J Public Health* 2014; 104:406–413
2. Elbogen EB, Johnson SC: The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry* 2009; 66:152–61
3. Hasting EJ, Hamberger LK: Sociodemographic predictors of violence. *Psychiatr*

Clin North Am 1997; 20:323–335

4. Tardiff K: Clinical risk assessment of violence, in *Textbook of Violence Assessment and Management*. Edited by Simmon RI, Tardiff K. Washington, DC, American Psychiatric Publishing, 2008, pp 3–16
5. Thienhaus OJ, Piasecki M: Assessment of psychiatric patient's risk of violence towards others. *Psychiatr Serv* 1998; 49:1129–1147
6. Beck JC: Outpatient settings, in *Textbook of Violence Assessment and Management*. Edited by Simmon RI, Tardiff K. Washington, DC, American Psychiatric Publishing, 2008, pp 237–258
7. Yudofsky SC, Silver JM, Jackson W, et al: The Overt Aggression Scale for the objective rating of verbal and physical aggression. *Am J Psychiatry* 1986; 143:35–39
8. Feinstein R, Plutchik R: Violence and suicide risk assessment in the psychiatric emergency room. *Compr Psychiatry* 1990; 21:337–343
9. Soyka M: Substance misuse, psychiatric disorder and violent and disturbed behavior. *Br J Psychiatry* 2000; 176:345–350

The American Journal of Psychiatry Residents' Journal: How to Get Involved

Residents, fellows, and students are invited to attend the **2015 American Journal of Psychiatry Residents' Journal** workshop, to take place at the American Psychiatric Association Annual Meeting in Toronto, Canada.

- Bring your thoughts and ideas about the *Residents' Journal*
- Hear a brief presentation about the Journal's new developments
- Meet with *Residents' Journal* editors and editorial staff
- Meet the *American Journal of Psychiatry* Editor-in-Chief
Robert Freedman, M.D.

Sunday, May 17, 2015
12:30 p.m. to 2:00 p.m.
Toronto Convention Centre—North
Level 200, Rooms 202 C/D



For further information please contact ajp@psych.org.

ajp.psychiatryonline.org



Web: www.appi.org
Phone: 1-800-368-5777
Email: appi@psych.org AH1509

Toward Forging a National Policy for Police Mental Health Training

Rehan Puri, M.D., M.P.H.

Concern over the interactions between law enforcement agencies and the mentally ill has been documented in American history as early as 1825 (1). Thus, programs to educate law enforcement officers in dealing with the mentally ill have long existed in the United States. The most notable of these models is the crisis intervention team model, which has been shown in the literature to result in decreased morbidity, mortality, and incarceration of the mentally ill upon its implementation in police departments (2). However, such programs are the result of local grass roots initiatives and are scattered inconsistently across the country, as well as within individual states (3). A national agenda on police mental health education in the United States remains lacking.

In 2005, it was reported that in the United States, >30% of primary referrals to psychiatric hospitals were made by law enforcement personnel (2). It is estimated that about 92% of mentally ill persons currently not hospitalized would have met criteria for hospitalization just a few decades ago (1). Consistent with the literature, numerous law enforcement personnel across the country are speaking out in the media, stating that they have been attempting to manage this segment of the nonhospitalized mentally ill population. However, not all law enforcement personnel across the nation are trained equally in handling encounters with mentally ill individuals (4).

The growing number of encounters between law enforcement and the mentally ill is an epidemic not only in the United States but internationally as well. The Mental Health Commission of Canada has set an international precedent by

A national agenda on police mental health education in the United States remains lacking.

conducting an unparalleled systematic and scientific review of both local Canadian and international police mental health education programs. The result has been the forging of an effective Canadian national strategy for law enforcement mental health education: The TEMPO (Training and Education about Mental Illness for Police Organizations) model. The TEMPO model does not replace existing mental health education programs in Canada, but it identifies core competencies needed in programs, such as recognizing mental illness and de-escalation techniques. Apart from providing a framework for mental health education programs, the Mental Health Commission of Canada provides didactic mental health training support to police departments in local municipalities (5).

Unlike Canada, in the United States, there is no cohesive national policy like the TEMPO model, nor is there a national agenda to ensure that encounters between the mentally ill and police are safeguarded. Crisis intervention team programs in the United States are initiated mainly by advocacy groups, such as the National Alliance for the Mentally Ill, in areas where people feel the need for such programs. State policies are in-

consistent as well. For example, Georgia has a statewide crisis intervention team initiative, whereas Alabama does not. In certain U.S. cities, such as Elgin, Illinois, police officers receive two tiers of crisis intervention team training, whereas cities in the state of Arkansas do not have such programs. We should work toward a national policy on police mental health training that not only identifies national gaps in training but rectifies them as well.

Dr. Puri is a third-year resident in the Department of Psychiatry, Bergen Regional Medical Center, Paramus, N.J.

The author thanks Srikanth Reddy, M.D., Attending Supervisor, and Taimur Mian, M.D., a research fellow at Bergen Regional Medical Center.

References

1. Torrey EF: Out of the Shadows: Confronting America's Mental Illness Crisis. New York, John Wiley, 1997
2. Vermette H, Pinals D, Appelbaum P: Mental health training for law enforcement professionals. *J Am Acad Psychiatry Law* 2005; 33:42-46
3. Oliva J, Compton M: A statewide crisis intervention team (CIT) initiative: evolution of the Georgia CIT program. *J Am Acad Psychiatry Law* 2008; 36:38-46
4. Bouscaren D: As run-ins rise, police train to deal with those who have mental illnesses. <http://www.npr.org/2014/09/23/349098691/as-run-ins-rise-police-take-crash-courses-on-handling-mentally-ill>
5. Coleman T, Cotton D: TEMPO: A contemporary model for police education and training about mental illness. *Int J Law Psychiatry* 2014; 37:325-333

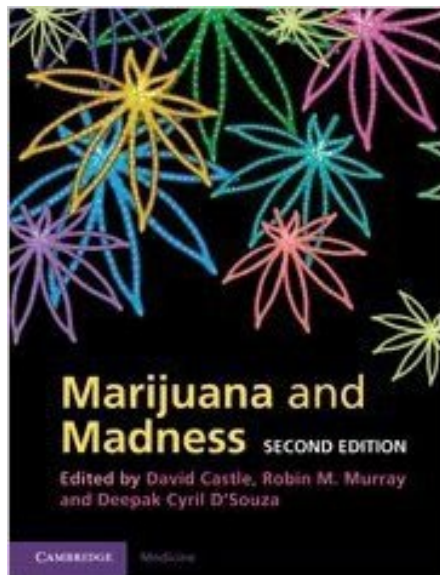
Marijuana and Madness, 2nd Edition Book Review

Edited by David Castle, Robin M. Murray, and Deepak Cyril D'Souza. New York, Cambridge University Press, 2011, 252 pp., \$99.99.

Perhaps one of the most topical medical and social issues today is marijuana. It would behoove psychiatrists to know as much as possible about this substance, not only as it relates to abuse and dependence but also as it relates to established mental illnesses such as schizophrenia. If psychiatrists wish for an update on the many intriguing questions about cannabis use, I would highly suggest the timely and highly relevant text *Marijuana and Madness*.

Edited by David Castle, Robin Murray, and, as of the second edition, Deepak D'Souza, the book brings together 26 linked chapters, all of which include well-researched academic articles. Each chapter is thematically organized and logically progresses from one aspect of psychiatry and marijuana to the next. The first few chapters deal with cannabinoids and their various mechanisms of action. Following the discussion on molecular biology, most of the book is devoted to the clinically focused interrelationship between the drug and mental disorders. The book concludes with more treatment-oriented chapters.

Those who have read the first edition (13 chapters) should not discount the second, since most of the original chapters have been replaced with more up-to-date literature. In addition, the second edition expands on the discussion of molecular biology with the inclusion of chapters that deal with neurodevelopment and the neural basis of cannabis and its acute ef-



fects. Also unique to the second edition is a chapter concerning the policy implications of marijuana and psychosis.

In contrast to the simplistic claims made by popular media, *Marijuana and Madness* makes it clear that this issue is anything but simple. Chapters successfully go beyond discussion of the direct psychomimetic effects of cannabis and touch on controversial topics such as “amotivational syndrome” and “cannabinoid psychosis.” Most controversial is the chapter on the policy implications of the evidence on cannabis and psychosis. The bottom line from the authors seems to be that it is complicated. Overall, they advocate caution in liberalizing cannabis laws

Review by Tony Pham, B.A.

in ways that may increase access in light of the current research.

One criticism is that while the book addresses the relationship between public policy and marijuana, the editors devote only one chapter to this matter. Moreover, while the authors mention reform policies and the effect of these policies on the liberalization of marijuana, they refrain from mentioning any relevant history that might help persons who are less up-to-date. These generalities are in contrast to the more detail-heavy molecular biology chapters. Given the changing health policies currently under way, I hope and expect that the editors will devote more of the third edition to the legal aspects of cannabis.

Overall, I would recommend this book not only to psychiatrists but to all mental health professionals because the material deserves to be widely circulated and digested among those who wish to take an active stance on the public policies surrounding marijuana. While clinicians and researchers who are interested in substance use disorders will benefit most from this book, understanding the impact of consumption on the evolving course of mental illness will be beneficial to any mental health worker.

Tony Pham is a fourth-year medical student at Tulane University School of Medicine, New Orleans.

SENIOR DEPUTY EDITOR POSITION 2015

Job Description/Responsibilities

- Frequent correspondence with AJP-Residents' Journal Editorial Board and AJP professional editorial staff.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with AJP editorial staff to prepare accepted manuscripts for publication to ensure clarity, conciseness, and conformity with AJP style guidelines.
- Collaborate with others as necessary to develop innovative ideas.
- Coordinate selection of book review authors and distribution of books with AJP professional editorial staff.
- Collaborate with the Editor-in-Chief in selecting the 2016 Senior Deputy Editor, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10–15 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-3 in July 2015, or a PGY-4 in July 2015 with plans to enter an ACGME fellowship in July 2016.
- Must be in a U.S. residency program.

Selected candidate will be considered for a 2-year position, including advancement to Editor-in-Chief. Applicants should e-mail a CV and personal statement of up to 750 words describing their professional interests, qualifications, and reasons for applying for the position, as well as ideas for journal development to rajiv.radhakrishnan@yale.edu. The **deadline** for applications is **February 15th, 2015**.

DEPUTY EDITOR POSITION 2015

Job Description/Responsibilities

- Frequent correspondence with Residents' Journal Editorial Board and AJP professional editorial staff.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with AJP editorial staff to prepare accepted manuscripts for publication to ensure clarity, conciseness, and conformity with AJP style guidelines.
- Collaborate with others as necessary to develop innovative ideas.
- Prepare a monthly Residents' Resources section for the Journal that highlights upcoming national opportunities for medical students and trainees.
- Collaborate with the Editor-in-Chief in selecting the 2016 Senior Deputy Editor, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2015, or a fellow in an ACGME fellowship in July 2015.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the Senior Deputy Editor position in 2016. If the selected candidate is interested in serving as Senior Deputy Editor in 2016, he or she would need to formally apply for the position at that time.

Applicants should e-mail a CV and personal statement of up to 750 words describing their professional interests, qualifications, and reasons for applying for the position, as well as ideas for journal development to rajiv.radhakrishnan@yale.edu. The **deadline** for applications is **February 15th, 2015**.

ASSOCIATE EDITOR POSITIONS 2015

*Two positions available

Job Description/Responsibilities

- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Manage the Test Your Knowledge questions on Facebook and work closely with authors in developing Board-style review questions for the Test Your Knowledge section.
- Collaborate with the Senior Deputy Editor, Deputy Editor, and Editor-in-Chief to develop innovative ideas for the Journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2015, or a fellow in an ACGME fellowship in July 2015
- Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2016. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2016, he or she would need to formally apply for the position at that time.

Applicants should e-mail a CV and personal statement of up to 750 words describing their professional interests, qualifications, and reasons for applying for the position, as well as ideas for journal development to rajiv.radhakrishnan@yale.edu. The **deadline** for applications is **February 15th, 2015**.

TEST YOUR KNOWLEDGE

Test Your Knowledge Has Moved

Our Test Your Knowledge feature, in preparation for the PRITE and ABPN Board examinations, has moved to our Twitter (www.twitter.com/AJP_ResJournal) and Facebook (www.facebook.com/AJPResidentsJournal) pages.

We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment for their questions.

Submissions should include the following:

1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.

**Please direct all inquiries to Rajiv Radhakrishnan, M.B.S., M.D., Senior Deputy Editor (rajiv.radhakrishnan@yale.edu).*

American Psychiatric Publishing has enhanced our **JOURNALS** with bold **new looks** and **engaging features!**



- Each issue's Table of Contents will include quick takeaways for each article to help readers quickly determine items to turn to or mark for later reading.
- Journal homepages will push the latest articles front and center as soon as they are published so that cutting-edge research articles are immediately discoverable.
- Symbols on the Table of Contents page and on the articles themselves will help readers navigate to content that addresses the Core Competencies as defined by the Accreditation Council of Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS).
- **More video content!** Journal editors discuss the decisions that led them to accepting various research papers and also highlight the clinical significance of content contained in each issue.

We are excited to be bringing these enhancements to you and look forward to telling you about upcoming innovations designed to ensure we continue to offer the definitive resource for the psychiatric knowledge base.



www.psychiatryonline.org

American Psychiatric Publishing • www.appi.org

Phone: 1-800-368-5777 • Email: appi@psych.org AH1508

Residents' Resources

We would like to welcome all our readers to this new feature of the Journal! Here we hope to highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

**To contribute to the Residents' Resources feature, contact Tobias Wasser, M.D., Deputy Editor (tobias.wasser@yale.edu).*

February Deadlines

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
APA Resident Recognition Awards Deadline: February 28, 2015	APA	Selection Criteria: <ul style="list-style-type: none"> • Compassion, as evidenced by exemplary patient care, and/or compassion toward colleagues and in the workplace; • Leadership in the field of psychiatry as evidenced by holding leadership roles in individual residency programs, at the district branch level of the APA and/or at the national level; • Community service at the local or national level; • Political action on behalf of patients, the profession, and/or the community; and • Clinical excellence as evidenced by exemplary patient care. 	Each institution may select one resident or fellow for this award annually. The trainee must be a member of the APA	Nancy Delanoche, M.S., American Psychiatric Association Office of Graduate and Undergraduate Education 1000 Wilson Blvd, Suite 1825 Arlington, VA 22209	http://www.psychiatry.org/residents/fellowships-awards/apa-resident-recognition-awards
American Psychoanalytic Association Fellowship Deadline: February 2015 (specific date TBD)	American Psychoanalytic Association	All qualified applicants receive a psychoanalyst mentor with whom they meet to discuss their interest in psychoanalysis, a free subscription to the newsletter of the Association, and complimentary registration at the biannual meetings of the Association.	Psychiatry applicants must at the time of the application be full-time general or child psychiatry residents, PGY-2 or higher, or fellows, or psychiatrists who have become Board eligible within the previous 3 years.	None listed	http://www.apsa.org/

March Deadlines

Alexandra and Martin Symonds Foundation Fellowship Deadline: March 1, 2015	The Association of Women Psychiatrists (AWP)	The goal of this award is to increase the exposure of female psychiatric residents to scientific endeavors that will enhance residents' understanding and commitment to the advancement of women's mental health and the exploration of the impact of gender related issues on the lives of both men and women. The fellowship will award a \$1,500 stipend for travel and participation in the AWP/APA Annual Meetings.	Psychiatry resident; AWP member	Frances Roton Bell e-mail: womenpsych@aol.com Phone: 972-613-0985	http://associationofwomenspsychiatrists.com/
AWP Fellowship Deadline: March 1, 2015	AWP	Annual fellowship for outstanding female psychiatry residents who have demonstrated significant potential for leadership and contribution in women's health. The fellowship will award a \$1,500 stipend for travel and participation in the AWP/APA Annual Meetings.	Psychiatry resident; AWP member	Frances Roton Bell e-mail: womenpsych@aol.com Phone: 972-613-0985	http://associationofwomenspsychiatrists.com/awards.aspx
Leah J. Dickstein, M.D., Award Deadline: March 1, 2015	AWP	Recognizes a female medical student who best exemplifies the spirit of creativity, energy, and leadership that Dr. Dickstein herself epitomizes and seeks to foster in others. The recipient will be expected to attend the Annual Meeting (in conjunction with the APA Annual Meeting) in May.	Female medical students who have demonstrated superior academic achievement, creativity, and leadership.	Frances Roton Bell e-mail: womenpsych@aol.com Phone: 972-613-0985	http://associationofwomenspsychiatrists.com/awards.aspx

Author Information for *The Residents' Journal* Submissions

Editor-in-Chief

Misty Richards, M.D., M.S.
(UCLA)

Senior Deputy Editor

Rajiv Radhakrishnan, M.B.B.S., M.D.
(Yale)

Deputy Editor

Tobias Wasser, M.D.
(Yale)

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted. To submit a manuscript, please visit <http://mc.manuscriptcentral.com/appi-ajp>, and select "Residents" in the manuscript type field.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
- 3. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
- 4. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
- 5. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
- 6. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 7. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Themes

Please note that we will consider articles outside of the theme.

Advances in Antidepressant Therapy

If you have a submission related to this theme, contact the Section Editor, Samuel Wilkinson, M.D. (samuel.wilkinson@yale.edu).

Childhood Trauma and Psychopathology

If you have a submission related to this theme, contact the Section Editor, Katherine Pier, M.D. (katherine.pier@mssm.edu).

Personality Disorders

If you have a submission related to this theme, contact the Editor-in-Chief Misty Richards, M.D., M.S. (mcrichards@mednet.ucla.edu).

*If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Misty Richards, M.D., M.S., Editor-in-Chief (mcrichards@mednet.ucla.edu).